STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445160	A. BUILDING _____ B. WING _____	08/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

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F 000	INITIAL COMMENTS During the annual recertification survey conducted at Mayfield Rehabilitation Center on August 2 - 4, 2010, complaints #TN00024574, TN00025420, TN00026134, and TN00026260 were investigated. No deficiencies were cited in relation to the complaints under 42 CFR PART 482.13, Requirements for Long Term Care.	[redacted]	It is the intention of the facility to resolve grievances the resident may have including those with respect to the behavior of other residents: 1. Dietary Manager and the Administrator met with an open forum of residents; including members of the Resident Council to review and discuss the current seasonal 5-week cycle of menus.	8/6/10
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on review of resident council minutes, and interview, the facility failed to resolve grievances in a timely manor for four residents of seven residents regarding variety of the menus. The findings included: Review of resident council meeting minutes of January 2010, through June 2010, revealed meal service and variety of menus to be of monthly concern. During the Group Interview conducted on August 2, 2010, at 1:30 p.m., four of seven residents interviewed voiced there was still not enough variety in the menus. Interview with the Certified Dietary Manager (CDM) August 3, 2010, at 10:30 A.M., in the training room, confirmed variety of the menu continued to be an issue due to limitations in the	F 166	Residents were offered an opportunity to make suggestions and recommendations for any changes to the menus based on resident preferences. Suggestions/recommendations were documented to sample copy of the 5-week cycle by the Dietary Manager. 2. The meeting that was held on 8/6/10 was open to all residents. A cross-section of the residents attended. All were offered an opportunity to express their concerns about the quality of the food, food preferences and modes of food preparation. 3. It was explained by the Dietary Manager and the Administrator that when the new seasonal cycle of menus are received, residents	8/6/10 8/6/10 8/6/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Hankins — TITLE: Administrator — (X6) DATE: 8/18/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AUG 19 2010

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	F 166, cont'd		will be notified and a resident meeting will be established, with the assistance of the Resident Council, to review the menus carefully and seek the residents suggestions and recommendations. Starting with the initial review date of 8/6/10, this will be an on-going process with each new menu cycle.	8/6/10
			Registered Dietitian will review the revisions to the menus for nutritional content.	8/20/10
			The approved, revised menus will be submitted to the facilities corporate compliance for implementation into the standard order guide used with the facilities electronic food purchasing system at the facility.	9/8/10
			Scheduled implementation for the revised menus is 9/13/10.	9/13/10
			Dietary staff will be inserviced on customer satisfaction, honoring residents preferences, meal preparation/appearance and taste testing the prepared product.	8/20/10
			To allow for a greater opportunity for residents to voice their opinions/ concerns, the Dietary Manager (or designee) and the cook will initiate random weekly rounds with at least 6 meals during the week and 2 meals during the weekend to seek residents feedback about the meal. Findings will be documented by the Dietary Manager and Cook and shared with	

AUG 19 2010

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F 166, cont'd			the dietary staff.	8/19/10
			Dietary Manager will meet with the Resident Council on a monthly basis for the next 6 months, beginning with the 8/30/10 Council meeting.	8/30/10
			Administrator will meet monthly with the Resident Council for the next 3 months and then if necessary will continue attending those meetings if the residents do not appear satisfied with the meal/dining program.	8/30/10
			Complaints/grievances will be entered onto a facility grievance form and the facility grievance policy will be implemented with the Dietary Manager responsible for responding and resolving any grievances voiced.	8/19/10
			As part of improving residents satisfaction with the meals, Dietary Mgr. is offering a monthly theme meal for all the residents. Theme: Hawaiian.	8/19/10
			We will also be having a special meal each month that is chosen by the residents: Special Meal: Chicken Enchiladas.	8/12/10
			The Dietary Manager and the Administrator will be taste testing sample trays no less than three times per week to assure for accuracy in taste and preparation.	8/17/10
			4. The Dietary Manager will measure the effectiveness of the action plan to improve the meal program by meeting with the Resident Council	

AUG 19 2010

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F 166, cont'd			each month for 6 months and if resolution has not been obtained, the meetings will extend another 6 months or longer if necessary. The results/findings of the weekly taste testing, random rounds by the Dietary Manager and Cooks, meetings with the Resident Council and outcome of the special/theme meals will be presented in the monthly CQI/QA & A Committee meeting. Taste testing and random rounds will continue as an on-going process. Meetings with the Resident Council will be determined upon the residents satisfaction and the CQI/QA & A Committee will review at the end of 6 months to determine the effectiveness and the need to continue the action plan. As of 8/26/10, the action plan will be presented at the monthly CQI/QA & A Committee meeting and on-going for another 5 months and then re-evaluation. Administrator will measure the effectiveness of the action plan through monthly meetings with the Resident Council for the next 3 months or longer if compliance has not been achieved. If any further interventions are necessary after this time, the Dietary Manager will be responsible to implement the new action plan and bring the plan forward to the CQI/QA & A for monthly review.	8/30/10 8/26/10

AUG 19 2010

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	F 166, cont'd		The Administrator will assure that the Dietary Manager will present the necessary/accurate data to support her action plan and to evaluate the effective ness through the data and feedback that is submitted to the CQI/QA & A Committee meeting. First meeting: The CQI/QA & A Committee consists of: Director of Nurses, a physician and at least, but not limited to three other team members from the facility staff.	8/26/10

AUG 19 2010

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F 166	Continued From page 1 selections available from the corporately contracted vendor. Continued interview confirmed the CMD attended resident council meetings from January to June, 2010, in response to complaints about the food. Interview with the Administrator August 4, 2010, at 10:45 a.m., in the training room, confirmed the grievances about variety of menus is ongoing, and the facility had not addressed the residents concerns regarding the variety of the menus.	[redacted]		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview,	F 280	It is the intent of the facility for a resident, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. 1. The care plan for resident #4 was revised to reflect that the resident had an infection which required isolation. 2. The DON audited all residents to reveal that no other residents had an infection which required isolation and subsequent care plan update. Audit was complete: 3. The MDS nurses were inserviced regarding responsibility of care plan development related to a resident with an infection w ho requires isolation. Completed on:	8/4/10 8/4/10 8/16/10

AUG 19 2010

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F 280	Continued From page 2 the facility failed to revise the care plan for one resident (#4) of twenty-nine residents reviewed. The findings included: Medical record review revealed Resident #4 was initially admitted to the facility on December 10, 2009, and readmitted on June 21, 2010, with diagnoses including Coronary Artery Disease, Coronary Artery Bypass Graft, Pacemaker Insertion, Osteoporosis, Gastroesophageal Reflux Disease, Diabetes, Congestive Heart Failure, Atrial Fibrillation, chronic Renal Insufficiency,Cellulitis Bilateral Lower Extremities, and Sacral Decubitus. Review of the Minimum Data Set (MDS) dated July 6, 2010, revealed the resident had moderately impaired cognitive status with both short and long-term memory deficits. Continued review of the MDS revealed the resident required assistance with activities of daily living and had an indwelling urinary catheter in place. Continued review of the medical record revealed a laboratory report dated July 19, 2010, which revealed the resident had Clostridium Difficile in the stool; contact isolation was ordered; and the resident was started on antibiotics. Review of the care plan revealed no listed problem the resident had Clostridium Difficile in the stool; the fact the resident required isolation; or the specific precautions to follow when caring for the resident. During interview with the Director of Nursing and MDS Coordinator on August 4, 2010, at 8:30 a.m., in the North Wing nurses' station, the MDS Coordinator confirmed the care plan failed to	F 280	4.The DON will audit all infections to determine the need for isolation and care plan development every month for a period of 6 months, then annually thereafter. The DON shall report progress of the plan of care to the CQI/QA & A Committee beginning 9/10 for consideration and additional interventions or deletions as necessary. Next scheduled meeting to present audit is 9/23/10. Plan of correction will be initial presented at this months CQI/QA & A Committee meeting. The Administrator shall audit the compliance with the plan of correction for care plan implementation for those residents identified with infection requiring isolation monthly for a period of three months beginning by 9/18/10, quarterly for a period of six months and then annually thereafter. Administrator will assure that the results of the monthly audit for care plan implementation will be brought to the CQI/QA & A each month and recommendations followed by the Director of Nurses. Process to begin with the 9/10 CQI/QA & A Committee meeting that is scheduled for 9/23/10.	8/26/10 9/13/10

AUG 19 2010

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F 280	Continued From page 3 address the fact the resident had an infection which required isolation; the type of isolation required; and specific precautions to follow when administering care to the resident.	[redacted]		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	It is the intent of the facility to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1.Resident #3, sacral wound showed no sign or symptom of infection as per the documentation in wound notes and Nurse Practioner's progress notes, dated 8/12/10 and 8/13/10 respectively. 2.The DON audited all residents that require wound care. The documentation reveals no signs or symptoms of infection per wound notes. The audit was completed: 3.Treatment Nurse #1 was counseled on 8/6/10 related to not following "Procedure for Hydrocolloid Dressing." Licensed staff were inserviced on "Procedure for Hydrocolloid	8/14/10 8/12/10 8/6/10

AUG 19 2010

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F 441	Continued From page 4 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to ensure staff followed the facility's policy for Infection Control during a dressing change for one (#3) resident and failed to place personal protective equipment in an appropriate location for a resident requiring isolation for one resident (#4) of twenty-nine residents reviewed. The findings included: Resident #3 was admitted to the facility on March 5, 2005, with diagnoses including Muscle Weakness, Dysphasia, Dementia, and Alzheimer's Disease. Medical record review of a physician order dated June 29, 2010, revealed " ...apply santyl to coccyx wound on M(Monday), T (Tuesday), W(Wednesday) after cleaning the area with NS (normal saline) and pat dry..." Observation of the resident in the resident's room on August 2, 2010, at 2:05 p.m., revealed Treatment Nurse #1 providing a dressing change to resident #3. Observation revealed Treatment Nurse #1 removed the old soiled dressing and cleansed the wound but failed to wash the hands or change the gloves prior to cleaning the wound. Review of the facility's policy for "Procedure for a	F 441	Dressing" with an emphasis on hand washing. 4.The DON will audit Treatment Nurse #1 dressing change technique every week for a period of 4 weeks, then every month for a period of 4 months, then annually thereafter. The DON shall report progress of this plan of care to the CQI/QA & A Committee beginning with the scheduled meeting on 9/23/10 for consideration and additional interventions as necessary. The Administrator shall audit the compliance with the plan of correction for auditing by the DON of those residents that require wound care and observation of the Treatment Nurses dressing change technique monthly for a period of three months, then annually thereafter. Administrator will assure that the results of the weekly/monthly audit for observation of the Treatment Nurse will be brought to the CQI/QA & A Committee each month and recommendations followed by the Director of Nurses. Process to begin with the 9/23/10 CQI/QA & A Committee meeting. The plan of correction will be presented during the 8/26/10 meeting of the CQI/QA & A Com-	8/20/10 9/13/10

AUG 19 2010

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F 441	Continued From page 5 Hydrocolloid Dressing" revealed " ...2. Remove old dressing ...3. Discard dressing and gloves ...4. Wash hands and apply second pair of gloves and use aseptic technique to cleanse or irrigate the wound ..." Interview with Treatment Nurse # 1 outside the resident room on August 2, 2010, at 2:32 p.m., revealed the facility policy for Treatment of Pressure Sores was not followed and infection control was not maintained during the dressing change. Medical record review revealed Resident #4 was initially admitted to the facility on December 10. 2009, and readmitted on June 21, 2010, with diagnoses including Coronary Artery Disease, Coronary Artery Bypass Graft, Pacemaker Insertion, Osteoporosis, Gastroesophageal Reflux Disease, Diabetes, Congestive Heart Failure, Atrial Fibrillation, chronic Renal Insufficiency,Cellulitis Bilateral Lower Extremities, and Sacral Decubitus. Review of the Minimum Data Set (MDS) dated July 6, 2010, revealed the resident had moderately impaired cognitive status with both short and long-term memory deficits. Continued review of the MDS revealed the resident required assistance with activities of daily living and had an indwelling urinary catheter in place. Continued review of the medical record revealed a laboratory report dated July 19, 2010, which revealed the resident had Clostridium Difficile in the stool; contact isolation was ordered; and the resident was started on antibiotics. Observation of the resident's room during the	F 441	mittee meeting. 5.Personal protective equipment (PPE) for resident #4 was moved to the entrance of resident's room. 6.On 8/3/10, the DON audited all residents records to reveal that no other resident had an infection which required isolation. 7.The Central Supply Coordinator was inserviced regarding proper placement of PPE. Licensed and certified staff were in-serviced on Standard Precautions with emphasis on Contact precautions and placement of PPE. 8.The DON will audit compliance of PPE placement in isolated resident rooms every month for a period of 3 months, then annually thereafter. The DON shall report progress of the plan of care to the CQI/QA & A Committee for consideration and additional interventions as necessary. This will begin with the 9/23/10 CQI/QA & A Committee meeting. The plan of correction will be submitted to the CQI/QA & A Committee on 8/26/10. The Administrator shall audit the compliance with the plan of correction for auditing by the DON for the proper placement of the PPE equipment for a resident in isolation for a period of three months, then annually thereafter.	8/26/10 8/3/10 8/3/10 8/16/10 8/20/10 8/26/10 9/13/10

AUG 19 2010

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F 441	Continued From page 6 initial tour on August 2, 2010, at 9:30 a.m., revealed the resident was in the bed beside the window. Further observation of the resident's room revealed a biohazard bag in a stand mid-way between the door and window. Continued observation of the resident's room revealed a three drawer plastic stand containing personal protective equipment on the floor between the biohazard bag and the window. Observation of the resident's room on August 3, 2010, at 7:40 a.m., revealed the same findings. During interview with the Director of Nursing on August 3, 2010, at 9:30 a.m., in the resident's room, confirmed the stand with personal protective equipment was inappropriately located in the room and should have been at the entrance to the room.	F 441	Administrator will assure that the results of the monthly audits will be brought to the monthly CQI/QA & A Committee meeting each month and recommendations will be followed by the DON. Process to begin with the 9/23/10 CQI/QA & A Committee meeting. The plan of correction will be presented during the 8/26/10 meeting of the CQI/QA & A Committee meeting.	8/26/10

AUG 19 2010